Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

EARL LABUGA PA
GULF COAST SPINE CARE LTD PA
1200 BINZ 670
HOUSTON TX 77004

Respondent Name
OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box
Box Number 44

MFDR Tracking Number
M4-05-8235-01

MFDR Date Received
MAY 10, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "(1) There is no code assigned to anterior lumbar diskectomy only thoracic, CPT code 63077. This procedure is usually reimbursed. (2) Bone morphogenic protein – application and preparation no CPT code has been assigned, but it is indeed a very isolated procedure see letter and operative note. (3) 22842-Insert spine device should be reimbursed. The insurance denial without a denial code reason."

Amount in Dispute: $5,113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Paid in accordance with fee schedule & fair and reasonable."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 2004	CPT Code 22899-AS	$1,738.00	$0.00
	CPT Code 22899-AS	$1,500.00	$0.00
	CPT Code 22842-AS	$1,875.00	$1,055.91
TOTAL		$5,113.00	$1,055.91

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 1, 2004
   - 04663-Fee Guideline MAR reduction
   - 01956-No MAR

   Explanation of benefits dated December 16, 2004 and April 22, 2005
   - 04835-Denial after reconsideration.

Issues

1. Did the requestor support position that amount sought in reimbursement for CPT code 22899-AS is fair and reasonable?
2. Is the requestor entitled to reimbursement for CPT code 22842-AS?

Findings

1. 28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   28 Texas Administrative Code §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

   CPT code 22899 is defined as "Unlisted procedure, spine." The requestor noted that CPT code 22899-AS was used for coding the following procedures: Anterior lumbar diskectomy and Bone morphogenic protein – application and preparation.

   CPT code 22899 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

   This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "There is no code assigned to anterior lumbar diskectomy only thoracic, CPT code 63077. This procedure is usually reimbursed. (2) Bone morphogenic protein – application and preparation no CPT code has been assigned, but it is indeed a very isolated procedure see letter and operative note."
   - The requestor does not discuss or explain how reimbursement of $1,738.00 and $1,500.00 for code 22899-AS is a fair and reasonable reimbursement.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

2. CPT code 22842-AS is defined as "Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)".

   Per Rule 134.202(b), the maximum allowable reimbursement, (MAR) is determined by locality. A review of Box 32 on CMS-1500 indicates that the zip code 77055 is the locality. This zip code is located in Harris County.

   28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

   The Medicare allowable for CPT code 22842 in Harris County is $844.73. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $1,055.91. The difference between the MAR and amount paid is $1,055.91. As a result, the amount ordered is $1,055.91.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,055.91.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,055.91 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	1/8/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.